

Patient's Name: _____ Date of Birth: _____
month/day/year

Patient's Plan of Care: Goals and Treatment Options

MUST be on the front of the active chart. MUST accompany the patient on any transfer.

Use of this form by a patient or the patient's proxy (health care agent or surrogate) is voluntary. It documents the patient's goals and any preferences or decisions by a patient/proxy about life-sustaining treatment options that might be considered in light of the patient's **current** circumstances. The patient's attending physician or another health care provider should discuss these options with the patient/proxy. This is not an advance directive, but this form can be used to clarify or apply an existing advance directive. The patient/proxy should initial any decisions and sign the form; the health care providers should also sign it. When the patient's condition changes, the form should be reviewed to see if any changes are necessary.

Part A Fill in briefly, then <i>initial</i> on the line →→→	Most Important Goal(s) of Care (Attempt to gain some improvement in condition, if possible? Prolong life as much as possible even with uncomfortable treatments? Emphasize comfort care over efforts to prolong life? Other?) _____
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Part B Fill in	Advance Directive and Contact Information. If the patient has a written advance directive, check this box <input type="checkbox"/> and <i>append copy</i> . Provide contact information for a proxy in case the patient lacks or loses capacity. _____ <p style="text-align: center;">Name and phone number of health care agent, if one has been named, or surrogate if not.</p>
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→ Decisions made below should serve the main goal(s) in Part A and, if made by a proxy, must be consistent with the patient's advance directive (if any). "Other" allows for decisions that modify or change what is preprinted or to state, "No decision at this time."

Part C <i>Initial.</i> Do <u>not</u> "✓" or "X"	Code Status _____ Yes, attempt cardiopulmonary resuscitation (CPR) _____ No, do not attempt CPR; allow death to occur naturally _____ Other:
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Part D <i>Initial.</i> Do <u>not</u> "✓" or "X"	Hospital Transfer Status _____ Transfer to hospital for any condition requiring hospital-level care _____ Transfer to hospital acceptable for evaluation of acute injury _____ Do not transfer; treat with options available outside the hospital _____ Other:
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Part E <i>Initial.</i> Do <u>not</u> "✓" or "X"	Medical Workup for significant and possibly treatable symptoms that could be evaluated through blood work, X-rays, etc. _____ All medical tests acceptable (treatment planned for diagnosed condition) _____ Limited (noninvasive, low risk) medical tests only _____ No medical tests _____ Other:
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Part F <i>Initial.</i> Do <u>not</u> “✓” or “X”	Antibiotics _____ Antibiotics acceptable _____ Antibiotics acceptable, but not by intravenous infusion _____ No antibiotics except if needed for comfort _____ Other:
Part G <i>Initial.</i> Do <u>not</u> “✓” or “X”	Artificial Ventilation _____ Artificial ventilation acceptable, even indefinitely _____ Artificial ventilation acceptable as therapeutic trial (time limit: _____) _____ No artificial ventilation _____ Other:
Part H <i>Initial.</i> Do <u>not</u> “✓” or “X”	Artificially Administered Fluids and Nutrition _____ Artificially administered fluids and nutrition acceptable, even indefinitely _____ Artificially administered fluids and nutrition acceptable as therapeutic trial (time limit: _____) _____ Intravenous fluids acceptable; no artificially administered nutrition _____ No artificially administered fluids and nutrition _____ Other:
Part I <i>Initial.</i> Do <u>not</u> “✓” or “X”	Other Life-Sustaining Treatments if Applicable Specify treatment: _____ _____ Acceptable, even indefinitely or repeatedly _____ Acceptable if recommended for an acute episode, but not indefinitely or repeatedly _____ Not acceptable _____ Other:

Name of Patient, Health Care Agent, or Surrogate (print, and circle which one) Signature	 Date
Name of Health Care Provider Assisting with Form (print) Signature	_____ Phone _____ Date
Physician Name (print) Physician Signature	_____ Phone _____ Date

Review: This Care Plan may be reviewed at any time – a review should occur whenever:

- ✓ The patient is transferred from one care setting or care level to another or is discharged, or
- ✓ The patient’s health status changes substantially, including loss of capacity, or
- ✓ The most important goal of care or specific treatment preferences change.

This Care Plan is not a physician’s order. It should be reviewed prior to the entry of new orders.